State of Tennessee
TENNESSEE ATHLETIC COMMISSION
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

Professional Athlete Dilated Eye Exam

Only a licensed Ophthalmologist or Optometrist may conduct this examination and complete this form.
Please complete this form in its entirety.

Participant's Full Name _____
Last First Middle

HISTORY: Please provide the following information:

Has applicant ever had any of the following conditions:

1. Blurred vision? [ ]Yes [ ]No
2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? [ ]Yes [ ]No
3. Has applicant had or been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? [ ]Yes [ ]No If yes, please explain:_____
4. Eye Disease? [ ]Yes [ ]No List nature of diseases or injuries:_____
5. Eye Injury? [ ]Yes [ ]No List nature of diseases or injuries:_____
6. Retinal re-attachment? [ ]Yes [ ]No If yes, please explain: _____
7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? [ ]Yes [ ]No If yes, please explain: _____

EXAMINATION:

VISION: Without / With Glasses REFRACTION: If either eye is 20/60 or worse:

Right _____/_____ Right _____ Sph_____ Cyl x_____ Acuity_____
Left _____/_____ Left _____ Sph_____ Cyl x_____ Acuity_____
Remarks: _____ Intraoccular Right_____mmHg
_____ Tension Left _____mmHg
_____ Motility Normal _____ Abnormal _____
_____ Binocular Vision Normal _____ Abnormal _____

SLIT LAMP EXAM:

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Conjunctiva			
Cornea_____	_____/_____	_____/_____	_____
Iris/Pupil_____	_____/_____	_____/_____	_____
Lens_____	_____/_____	_____/_____	_____
Eyelids_____	_____/_____	_____/_____	_____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil):

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Disc _____	_____/_____	_____/_____	_____
Macula _____	_____/_____	_____/_____	_____
Lens_____	_____/_____	_____/_____	_____
Peripheral Retina _____	_____/_____	_____/_____	_____

EXAMINING PHYSICIAN:

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? [ ]Yes [ ]No
If no, please explain:

_____

_____

_____	_____	_____
Licensed Physician's Name (print)	Medical License No.	Applicant Name (print)
_____		_____
Address/ City/ State/ Zip Code		Applicant Signature
_____		_____
Physician's Signature		Date/ Time

Authorization to Use and Disclose Protected Health Information

I hereby authorize _____ (Physician) to furnish to the Tennessee State Athletic Commission (the "Commission"), or its successors, copies of all my medical records, hospital records, records of treatment for drug and/or alcohol abuse or dependency, or other information requested by the Commission in connection with my application for licensure by the Commission or any further or future investigation by the Commission necessary to determine my fitness for licensure.

I further authorize the Commission or its successors to release any medical or other personal information with respect to my application or licensure to those athletic commissions (or similar regulatory bodies) that have a need to know, as determined by the Commission. This disclosure of records is required for official use, including investigation of my fitness for licensure by the Commission. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to receive a copy of this authorization if I request it. I may inspect or obtain a copy of the protected health information that I am being asked to disclose.

I understand that I have a right to revoke this authorization by sending written notification to the Tennessee State Athletic Commission, 500 James Robertson Parkway, Nashville, TN 37243. I understand that if I revoke this authorization, I may not be allowed to continue in the licensure process, or, if I am licensed, my license may be adversely affected.

This authorization shall remain valid for one year from the date a license is issued to me. A copy of this authorization shall be as valid as the original.

_____
Name (Print)

_____ _____
Signature Date